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ABSTRACT

Nine fact sheets relevant to children's emotional well-being are presented in this document. The first fact sheet, "Teenagers with Eating Disorders" focuses on anorexia nervosa and bulimia. The second fact sheet, "Children and Grief" describes age-related responses to death, and ways of coping with a death in a family that includes children. The third fact sheet, "Teen Suicide" describes conditions that can lead to adolescent suicide and warning signs that parents should recognize. Patients are also urged to recognize depression and suicidal feelings as treatable mental disorders. The fourth fact sheet, "Children of Alcoholics" discusses the risks for children of alcoholic parents. Benefits of professional help and support groups are described. The fifth fact sheet, "Stepfamily Problems" looks at the challenges faced by new stepfamilies. Suggestions are given for building strong bonds. The sixth fact sheet, "Helping Children after a Disaster" provides tips and insights to help parents consider the effects of a catastrophe on their children. Symptoms and changes that may indicate Post-Traumatic Stress Disorder are described. The seventh fact sheet, "Manic-Depressive Illness in Teens" describes the symptoms of manic-depressive illness, also known as bipolar mood disorder. The eighth fact sheet, "Children of Parents with Mental Illnesses" discusses the risks of mental illnesses for children, and lists protective or positive factors that can decrease the risk. The ninth fact sheet, "Making Decisions about Substance Abuse Treatment" provides questions for parents to ask when substance abuse treatment is recommended. In most of the fact sheets, symptoms and warning signs are listed. (LLL)

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from the American Academy of Child and Adolescent Psychiatry

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Facts for Families

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No. 2 (7/91)

TEENAGERS WITH EATING DISORDERS

Overeating related to tension, poor nutritional habits and food fads are relatively common eating problems for youngsters. In addition, two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among teenage girls and young women. These two disorders also occur in boys, but much less often. The child and adolescent psychiatrist is trained to evaluate, diagnose, research and treat these psychiatric disorders. Often they are asked to help teenagers who suffer from anorexia nervosa and bulimia, characterized by a preoccupation with food.

Parents frequently ask how to identify symptoms of anorexia nervosa and bulimia. The fact is that many teenagers are successful in hiding these serious and sometimes fatal disorders from their families for many months or even years.

Parents can be on the lookout for various symptoms and warning signs of anorexia nervosa and bulimia:

o A teenager with anorexia nervosa is typically a perfectionist and a high achiever in school. At the same time, she suffers from low self-esteem, irrationally believing she is fat regardless of how thin she becomes. Desperately needing a feeling of mastery over her life, the teenager with anorexia nervosa experiences a sense of control only when she says "no" to the normal food demands of her body. In a relentless pursuit to be thin, the girl starves herself. This often reaches the point of serious damage to the body, and in a small number of cases may lead to death.

o The symptoms of bulimia are different from those of anorexia nervosa. The patient binges on huge quantities of high-caloric food and then purges her body of

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dreaded calories by self-induced vomiting and often by using laxatives. These binges may alternate with severe diets, resulting in dramatic weight fluctuations. Teenagers may try to hide the signs of throwing up by running water while spending long periods of time in the bathroom. The purging of bulimia presents a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs.

With proper treatment, teenagers can be completely relieved of the symptoms or helped to control these disorders. Parents who notice symptoms of anorexia or bulimia in their teenagers should ask their family physician or pediatrician for referral to a child and adolescent psychiatrist who works comprehensively and effectively in treating these disorders.

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CHILDREN AND GRIEF

When a family member dies, children react differently from adults. Preschool children usually see death as temporary and reversible--a belief reinforced by cartoon characters who "die" and "come to life" again. Children between five and nine begin to think more like adults about death, yet they still believe it will never happen to them or anyone they know.

Adding to a child's shock and confusion at the death of a brother, sister or parent is the unavailability of other family members, who may be so shaken by grief that they are not able to cope with the normal responsibility of child care.

Parents should be aware of normal childhood responses to a death in the family, as well as danger signals. According to child and adolescent psychiatrists, it is normal during the weeks following the death for some children to feel little immediate grief or persist in the belief that the family member is still alive. But long-term denial of the death or avoidance of grief is unhealthy and can later surface in more severe problems.

A child who is frightened about attending a funeral should not be forced to go; however, some service or observance is recommended, such as lighting a candle, saying a prayer or visiting the grave site.

Once children accept the death, they are likely to display their feelings of sadness on and off over a long period of time, and often at unexpected moments. The surviving relatives should spend as much time as possible with the child, making it clear that the child has permission to show his or her feelings openly or freely.

The person who has died was essential to the stability of the child's world, and anger is a natural reaction. The anger may be revealed in boisterous play, nightmares, irritability or a variety of other behaviors. Often the child will show anger towards the surviving family members.

After a parent dies, many children will act younger than they are. The child may

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temporarily become more infantile, demanding food, attention and cuddling, and talking "baby talk."

Younger children believe they are the cause of what happens around them. A young child may believe a parent, grandparent, brother or sister died because he or she had once "wished" the person dead. The child feels guilty because the wish "came true." Some danger signals to watch for:

- An extended period of depression in which the child loses interest in daily activities and events.
- Inability to sleep, loss of appetite, prolonged fear of being alone.
- Acting much younger for an extended period.
- Excessively imitating the dead person; repeated statements of wanting to join the dead person.
- Withdrawal from friends.
- Sharp drop in school performance or refusal to attend school.

These warning signs indicate that professional help may be needed. A child and adolescent psychiatrist can help the child accept the death and assist the survivors in helping the child through the mourning process.

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TEEN SUICIDE

Suicides among young people nationwide have increased dramatically in recent years. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15- to 24-year-olds, and the sixth leading cause of death for 5- to 14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up.

For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. In some cases, suicide appears to be a "solution."

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the symptoms of suicidal feelings are similar to those of depression. Parents should be aware of the following warning signs of adolescents who may try to kill themselves. Child and adolescent psychiatrists recommend that if one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help when the concerns persist.

- Change in eating and sleeping habits.
- Withdrawal from friends, and family and regular activities.
- Violent actions, rebellious behavior or running away.
- Drug and alcohol use.
- Unusual neglect of personal appearance.
- Marked personality change.
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork.
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities.
- Not tolerating praise or rewards.

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A teenager who is planning to commit suicide may also:

- Complain of being "rotten inside."
- Give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," "I won't see you again."
- Put his or her affairs in order--for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- Become suddenly cheerful after a period of depression.

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take the statement seriously and seek immediate evaluation from a child and adolescent psychiatrist or other physician. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than "putting thoughts in the child's head," such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

With support from family and friends and professional treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

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CHILDREN OF ALCOHOLICS

At least seven million American children have alcoholic parents. Child and adolescent psychiatrists know these children are at greater risk for having emotional problems than children whose parents are not alcoholics. Alcoholism runs in families, and children of alcoholics are four times more likely than other children to become alcoholics.

A child in such a family may have a variety of problems:

- Guilt. The child may see himself or herself as the main cause of the mother's or father's drinking.
- Anxiety. The child may worry constantly about the situation at home. He or she is afraid the alcoholic parent will become sick or injured, and may also fear fights and violence between the parents.
- Embarrassment. Parents may give the message that there is a terrible secret at home. The ashamed child does not invite friends home and is afraid to ask anyone for help.
- Inability to have close relationships. Because the child has been disappointed by the drinking parent many times, he or she often does not trust others.
- Confusion. The alcoholic parent will change suddenly from being loving to angry, regardless of the child's behavior. A regular daily schedule, which is very important for a child, does not exist because bedtimes and mealtimes are constantly changing.
- Anger. The child feels anger at the alcoholic parent for drinking, and may be angry at the non-alcoholic parent for lack of support and protection.
- Depression. The child feels lonely and helpless to change the situation.

Although the child tries to keep the alcoholism a secret, teachers, relatives, other adults or friends may sense that something is wrong. Child and adolescent psychiatrists advise that the following behaviors may signal a drinking problem at home:

- Failure in school; truancy.
- Lack of friends; withdrawal from classmates.
- Delinquent behavior, such as stealing or violence.
- Frequent physical complaints, such as headaches or stomachaches.
- Abuse of drugs or alcohol.
- Aggression towards other children.

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Some children of alcoholics may act like responsible "parents" within the family and among friends. They may cope with the alcoholism by becoming controlled, successful "overachievers" throughout school, and at the same time be emotionally isolated from other children and teachers. Their emotional problems may show only when they become adults.

Whether or not their parents are receiving treatment for alcoholism, these children and adolescents can benefit from educational programs and mutual-help groups such as programs for children of alcoholics, Al-Anon and Alateen. Professional help, the earlier the better, is also important in preventing more serious problems for the child, including alcoholism. Child and adolescent psychiatrists help these children with their own problems, and also help them to understand they are not responsible for the drinking problems of their parents.

The treatment program may include group therapy with other youngsters, which reduces the isolation of being a child of an alcoholic. The child and adolescent psychiatrist will often work with the entire family--particularly when the alcoholic parent has stopped drinking--to help them develop healthier ways of relating to one another.

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No. 27 (7/91)

STEPFAMILY PROBLEMS

A new stepfamily faces many challenges. Stepfamily members have experienced important losses. They have no shared family histories or shared ways of doing things, and they may have very different beliefs. As with any achievement, developing good stepfamily relationships requires a lot of effort.

According to child and adolescent psychiatrists, a youngster may feel torn between the parents he or she lives with, and the "divorced" parent who lives somewhere else. In addition, newly married couples may not have enough time alone to adjust to their new relationship.

If these challenges are faced creatively, members of the "blended" family can help build strong bonds among themselves through:

- Mourning their losses;
- Developing new skills in making decisions as a family;
- Fostering and strengthening new relationships between parents, as well as stepparent-to-stepchild and stepsibling-to-stepsibling; and
- Supporting one another in maintaining original parent-child relationships.

While facing these issues may be difficult, most stepfamilies do work out their problems by consulting grandparents, clergy, support groups and other community based programs. But parents should consider getting a psychiatric evaluation when any family member feels:

- Alone dealing with the losses;
- Torn between 2 parents or 2 households;
- Excluded;
- Isolated by feelings of guilt and anger;
- Unsure about what is right, or
- Uncomfortable with any member of the original family or stepfamily.

The following signs, if they are lasting or persistent, also suggest the need for a psychiatric evaluation:

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- The child vents his or her anger upon a particular family member.
- One of the parents suffers from great stress and is unable to help with the child's increased needs and anger.
- A stepparent or parent openly favors one of the children, or a child resents a stepparent or parent.
- Only the natural parent, not the stepparent, is in charge of disciplining the child.
- Any member of the family gets no enjoyment from normally pleasurable activities such as learning, going to school, working, playing, or being with friends or family.

Most stepfamilies--when given the needed time to work on developing their own traditions and to form new relationships--can provide emotionally rich and lasting relationships for the adults, and help the children develop the self-esteem and strength to enjoy the challenges of life.

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HELPING CHILDREN AFTER A DISASTER

A catastrophe such as an earthquake, hurricane, tornado, fire or flood is frightening to children and adults alike. It is important to acknowledge the frightening parts of the disaster when talking with a child about it. Falsely minimizing the danger will not end a child's concerns. Several factors affect a child's response to a disaster.

The way children see and understand their parents' response is very important. Children are aware of their parents' worries most of the time but they are particularly sensitive during a crisis. Parents should admit their concerns to their children, and also stress their abilities to cope with the situation.

A child's reaction also depends on how much destruction he or she sees during and after the disaster. If a friend or family member has been killed or seriously injured, or if the child's school or home has been severely damaged, there is a greater chance that the child will experience difficulties.

A child's age affects how the child will respond to the disaster. For example, six-year-olds may show their concerns about a catastrophe by refusing to attend school, whereas adolescents may minimize their concerns but argue more with parents and show a decline in school performance. It is important to explain the event in words the child can understand.

Following a disaster, people may develop Post-Traumatic Stress Disorder (PTSD), which is psychological damage that can result from experiencing, witnessing or participating in an overwhelmingly traumatic (frightening) event. Children with this disorder have repeated episodes in which they re-experience the traumatic event. Children often relive the trauma through repetitive play. In young children, distressing dreams of the traumatic event may change into nightmares of monsters, of rescuing others or of threats to self or others.

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PTSD rarely appears during the trauma itself. Though its symptoms can occur soon after the event, the disorder often surfaces several months or even years later.

Parents should be alert to these changes:

- o Refusal to return to school and "clinging" behavior, shadowing the mother or father around the house;
- o Persistent fears related to the catastrophe (such as fears about being permanently separated from parents);
- o Sleep disturbances such as nightmares, screaming during sleep and bedwetting, persisting more than several days after the event;
- o Loss of concentration and irritability;
- o Behavior problems--for example, misbehaving in school or at home in ways that are not typical for the child;
- o Physical complaints (stomachaches, headaches, dizziness) for which a physical cause cannot be found;
- o Withdrawal from family and friends, listlessness, decreased activity, preoccupation with the events of the disaster.

Professional advice or treatment for children affected by a disaster--especially those who have witnessed destruction, injury or death--can help prevent or minimize PTSD. Parents who are concerned about their children can ask their pediatrician or family doctor to refer them to a child and adolescent psychiatrist.

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Facts for Families

from the American Academy of Child and Adolescent Psychiatry
No. 38 (3/91)

MANIC-DEPRESSIVE ILLNESS IN TEENS

Teenagers with manic-depressive illness have an ongoing combination of extremely high (manic) and low (depressed) moods. Highs may alternate with lows, or the person may feel both extremes at close to the same time. Professionals also refer to manic-depressive illness as bipolar mood disorder.

Manic-depressive illness usually starts in adult life, before the age of 35. Although rare in young children, it does occur in teenagers. This illness can affect anyone. However, if one or both parents have manic-depressive illness, the chances are greater that their children will develop the disorder.

Manic-depressive illness may begin either with manic or depressive symptoms. **The manic symptoms include:**

- Severe changes in mood compared to others of the same age and background--either unusually happy or silly, or very irritable.
- Unrealistic highs in self-esteem--for example, a teenager who feels specially connected to God.
- Great energy increase; ability to go with little or no sleep for days without feeling tired.
- Increased talking--the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted.
- Distractibility--the teen's attention moves constantly from one thing to the next.
- High risk-taking behavior, such as jumping off a roof with the belief that this will not cause injury.

The depressive symptoms include:

- Persistent sadness; frequent crying; depression.
- Loss of enjoyment in favorite activities.
- Frequent complaints of physical illnesses such as headaches or stomachaches.
- Low energy level, poor concentration, complaints of boredom.
- Major change in eating or sleeping patterns, such as oversleeping or overeating.

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Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia. The diagnosis can only be made with careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist can be helpful in identifying the problems--manic-depressive or other--and starting specific treatment.

Teenagers with manic-depressive illness can be effectively treatment. Effective treatment for manic-depressive illness usually includes education of the patient and the family about the illness, medication such as lithium, and psychotherapy. Lithium often reduces the number and severity of manic episodes, and also helps to prevent depression. Psychotherapy helps the teenager understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

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Facts for Families

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No. 39 (3/91)

CHILDREN OF PARENTS WITH MENTAL ILLNESSES

Mental illnesses in parents represent a risk for children in the family. These children have a higher risk for developing mental illnesses than other children.

The risk is particularly strong when the parent's illness is manic-depressive illness, schizophrenia, alcoholism or other drug abuse, or major depression. When both parents are mentally ill, the chance is even greater that the child might become mentally ill.

Risk can be inherited from parents, through the genes. Some of the risk also comes from parents' behavior or moods. Mental disorders can keep parents from providing the love and guidance necessary for a child's healthy development. An inconsistent, unpredictable family environment contributes to psychiatric illness in children. Mental illness can hurt the marriage and the parenting abilities of the couple, which in turn hurts the child.

Some protective or positive things can decrease the risk to children, including:

- Children knowing their parents are ill and that the children are not to blame.
- A stable home environment.
- A sense of being loved by the ill parent.
- A naturally stable and happy personality in the child.
- Inner strength and good coping skills in the child.
- A strong relationship with a healthy adult.
- Friends.
- Interest in and success at school.
- Other outside interests for the child.
- Help from outside the family to improve the family environment (for example, marital psychotherapy, or a class in parenting).

Medical, mental health or social service professionals working with mentally ill adults need to inquire about the children and adolescents, especially about their mental health and

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emotional development. It is often useful for such youngsters to be referred to a child and adolescent psychiatrist for an evaluation.

Individual or family psychiatric treatment can help a child toward healthy development despite the problems of the parental psychiatric illness. The child and adolescent psychiatrist can help the family work with the positive elements in the home and the natural strengths of the child. With treatment, the family can learn ways to lessen the effects of the parent's mental illness on the child.

Unfortunately, families, professionals and society often pay most attention to the mentally ill parent, and ignore the children in the family. Providing more attention and support to the children of a psychiatrically ill parent is an important way to help prevent mental illnesses from passing from one generation to the next.

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No. 41 (3/91)

MAKING DECISIONS ABOUT SUBSTANCE ABUSE TREATMENT

Many children and adolescents use alcohol and other drugs. Some develop serious problems.

There are many types of substance abuse treatment--based in offices, special treatment centers, and hospitals. The decision to entrust a child or adolescent to any type of treatment deserves serious consideration. Parents are encouraged to seek consultation from a child and adolescent psychiatrist when making decisions about substance abuse treatment for children or adolescents.

Properly informed, parents and families can contribute effectively to the treatment process. By asking the following questions when substance abuse treatment is recommended, parents can obtain important information.

1. Why do you believe this treatment in this program is indicated for my child? How do the other kinds of care compare: treatment in a psychiatric hospital, an inpatient specialized substance abuse treatment program, an educational program, a residential substance abuse treatment program, a day treatment program, outpatient treatment, a mutual-help program such as Alcoholics Anonymous or Narcotics Anonymous, or no treatment at this time?

2. What are the credentials and experience of the members of the treatment team, and will the team include a child and adolescent psychiatrist with knowledge and skills in substance abuse treatment?

3. What treatment approaches does this program use regarding chemical dependency; detoxification; abstinence; individual, family and group therapy; use of medications; a twelve-step program; mutual-help groups; relapse prevention; and a continuing recovery process?

4. Based on your evaluation, does my child have other psychiatric problems in addition to the substance abuse problem? If so, will these be addressed in the treatment process?

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5. How will our family be involved in our child's substance abuse treatment--including the decision for discharge and the after-care?

6. How will my child continue education while in treatment?

7. If this treatment is provided in a hospital or residential program, is it approved by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)? Is this substance abuse treatment program a separate unit accredited for youngsters of our child's age?

8. How will the issue of confidentiality be handled during and after treatment?

9. How long will this phase of the treatment process continue? Will we reach our insurance limit before treatment in this phase is completed?

10. When my child is discharged from this phase of treatment, how will it be decided what types of ongoing treatment will be necessary, how often, and for how long?

Parents should be careful not to be pressured into a treatment decision. If questions or doubts persist, a second opinion may be helpful.

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